

BEST PRACTICE

THE LATEST IN BEST PRACTICE AT ST ANDREW'S WAR MEMORIAL HOSPITAL

JULY 2013 | ISSUE 3



Queensland's first private hybrid theatre coming to St Andrew's War Memorial Hospital

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- Cardiac care in a brave new world
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Update

Highlighting the innovative use of new technologies

Welcome back to the third edition of St Andrew's War Memorial Hospital's *Best Practice* in which we continue to showcase medical innovation and the outstanding clinical services offered by our visiting medical practitioners (VMPs).

The innovative use of new technologies has been a hallmark of St Andrew's in recent decades and the work that we are going to discuss in this edition will highlight this ongoing commitment. The work being undertaken by clinics such as the Queensland Cardiovascular Group, Spring Hill Specialist Group and Queensland Vascular evidences ground breaking use of new technologies in the delivery of patient services.

St Andrew's War Memorial Hospital continues its strong connection with regional and rural GPs through showcasing the rich and rewarding experiences on offer to those GPs choosing to work in those areas. Our conversation with Dr John Hall in Oakey (just west of Toowoomba) highlights the rewarding combination of professional engagement through research and innovation with the family-friendly rural lifestyle that he has been able to achieve.

Our exciting CPD program for 2013 was launched with the Hypothetical hosted by Mr Geoffrey Robertson QC in March earlier this year. The event was a resounding success and those present were treated to a stimulating evening of debate, humour and intellectual tug-of-war. Our next CPD event of the GP Medical Series is the Q&A evening, hosted by the ABC's Tony Jones. It promises to be a lively and robust event on the topics that matter, and I hope to see as many as possible of you there to ask the hard questions.



Dr Christian A.C. Rowan

MBBS (Qld) MDipITrade (Mon) FRACGP
FARGP FACRRM FRACMA FACHAM (RACP)
Deputy Chief Medical Officer – Uniting Care Health
Director of Medical Services – St Andrew's War Memorial Hospital

ON THE COVER: (From left) Endovascular surgeons Dr Toby Cohen and Dr Andrew Cartmill from Queensland Vascular.

New doctors welcomed

Dr David Cavallucci

MBBS FRACS General Surgeon
T 07 3876 7455

Dr David Cavallucci is Brisbane raised and completed his medical studies at the University of Queensland. Dr Cavallucci's early training was at the Princess Alexandra Hospital in Brisbane and he completed his rural terms at Goondowindi, Childers, and Dirranbandi.



Dr Cavallucci concluded his surgical training in Sydney and following his FRACS completed a post fellowship year studying laparoscopic hepatobiliary, upper gastrointestinal and bariatric surgery. A second fellowship year followed in Brisbane where he worked in advanced hepatobiliary surgery at the Royal Brisbane Hospital. Dr Cavallucci was then offered a position in Toronto, Canada working in liver, kidney and pancreas transplantation to complete his American Society of Transplant Surgeons accreditation.

Dr Cavallucci is now based at St Andrews Hospital as a VMP in general surgery with a specific focus on liver, gall bladder and pancreas oncology and benign diseases. With David's extensive background in transplantation, he is also doing a large proportion of specialist surgery dealing with major vascular resection and hopes to continue his work with transplantation in the future.

Dr Tom Zhou

MBBS FRACP Gastroenterologist
T 07 3861 4866

Dr Zhou grew up in Brisbane and completed his medical studies at the University of Queensland. He completed his internship and basic physician training at Princess Alexandra Hospital in Brisbane. Dr Zhou then undertook three years of advanced training in gastroenterology at Townsville and Royal Brisbane and Women's Hospital.



After completing his gastroenterology training in 2011, Dr Zhou returned to Princess Alexandra Hospital in Brisbane in 2012 and spent a further year completing his liver fellowship. At the beginning of 2013 Dr Zhou commenced private practice with rooms at Holy Spirit Northside Hospital, Chermiside and sessional suites here at St Andrew's. In addition to his private patients, Dr Zhou is also part of the on-call roster for the St Andrew's Emergency Centre.

Dr Zhou enjoys all aspects of gastroenterology including general gastroenterology, inflammatory bowel disease, and endoscopic procedures. Dr Zhou's sub-specialty interest is liver diseases where he manages a number of conditions including viral hepatitis, fatty liver disease and hemochromatosis. Tom is a passionate football supporter and will be following the Socceroos closely in their preparation for the World Cup in Brazil next year.

Dr Janusz Bonkowski

MBBS FRACS Neurosurgeon
T 07 3833 2500

Dr Janusz Bonkowski was born in Belgium and emigrated to Australia with his family at the age of two. Dr Bonkowski grew up in Adelaide and completed his medical studies at the University of Adelaide.



Following completion of his medical studies, Dr Bonkowski moved to the United Kingdom where he spent the next seven years working in general surgery, and eventually neurosurgery. Following his training in the UK and working in hospitals in Yorkshire, Sheffield and Leeds Dr Bonkowski moved again, this time to New Zealand where he spent the next 30 years working in hospitals in Auckland and Christchurch.

Dr Bonkowski raised a family (four children in New Zealand) but was on the move once again following the 2011 earthquake and subsequent aftermath which lead to, among other things, the demolition of his practice rooms. With a damaged home, demolished practice and limited functionality at the local hospital, Janusz accepted a locum position at Royal Brisbane Hospital to take a break from Christchurch and the general disruption.

Following a locum at the RBH Dr Bonkowski accepted a position as a neurosurgeon with Briz Brain specializing primarily with chronic spinal cases. Janusz often jokes that the earth had to move to get him to St Andrew's.

Dr Marosh Vrtik

MBBS FRACS Cardiothoracic Surgeon
T 07 3353 5942

After graduating from the University of Western Australia, Dr Vrtik commenced his early surgical training at the Royal Perth Hospital. He undertook his cardiothoracic surgical training in Queensland at both the Prince Charles and Princess Alexandra Hospitals in Brisbane.



Dr Vrtik recently returned to Brisbane after completing two clinical fellowships. In 2011, he spent twelve months at The Papworth Hospital, Cambridge, UK gaining further experience in adult cardiac surgery. In 2012, he concentrated on expanding his special interest in thoracic surgery at St Vincent's Hospital in Melbourne with a particular focus on video assisted Thoracic Surgery (VATS) including VATS lobectomy.

Dr Vrtik commenced private practice at St Andrew's War Memorial Hospital in 2013. In addition to general cardiac surgery, he has a keen interest in thoracic surgical oncology and video assisted thoracic surgery.



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The Hybrid Theatre

An efficient and minimally invasive approach to vascular surgery

Vascular surgery has undergone significant changes especially over the last ten years. The vast majority of pathologies including aneurysms, carotid disease and lower limb occlusions can all be treated percutaneously with shorter hospital stays.

Traditionally, vascular surgeons worked primarily with open operations, but training has changed considerably in recent years with a larger emphasis on ultrasound and the endovascular skills associated with angiograms and angioplasties. This has resulted in the scope of vascular surgical practice changing with 70% of the work being done endovascularly and only 30% with open surgical intervention.

St Andrew's War Memorial Hospital is in the final stages of constructing a hybrid operating theatre which combines the advantages of an operating theatre with the image quality of a radiology suite. This will allow vascular surgeons to combine open surgical intervention with angioplasty and stenting at the same procedure. A hybrid operating theatre provides an environment for the more efficient treatment of difficult vascular pathologies and the facilitation of shorter hospital stays for our patients.

The key infrastructure in the hybrid theatre is the C-arm, a flexible imaging system suspended from the ceiling. The C-arm can be moved over or under any part of the patient delivering three

dimensional, high definition on-the-spot imaging. The C-arm can take everything from X-rays to CT scans and during an operation or procedure, surgeons are able to monitor the progress and accuracy of their work in real time on monitors in the theatre.

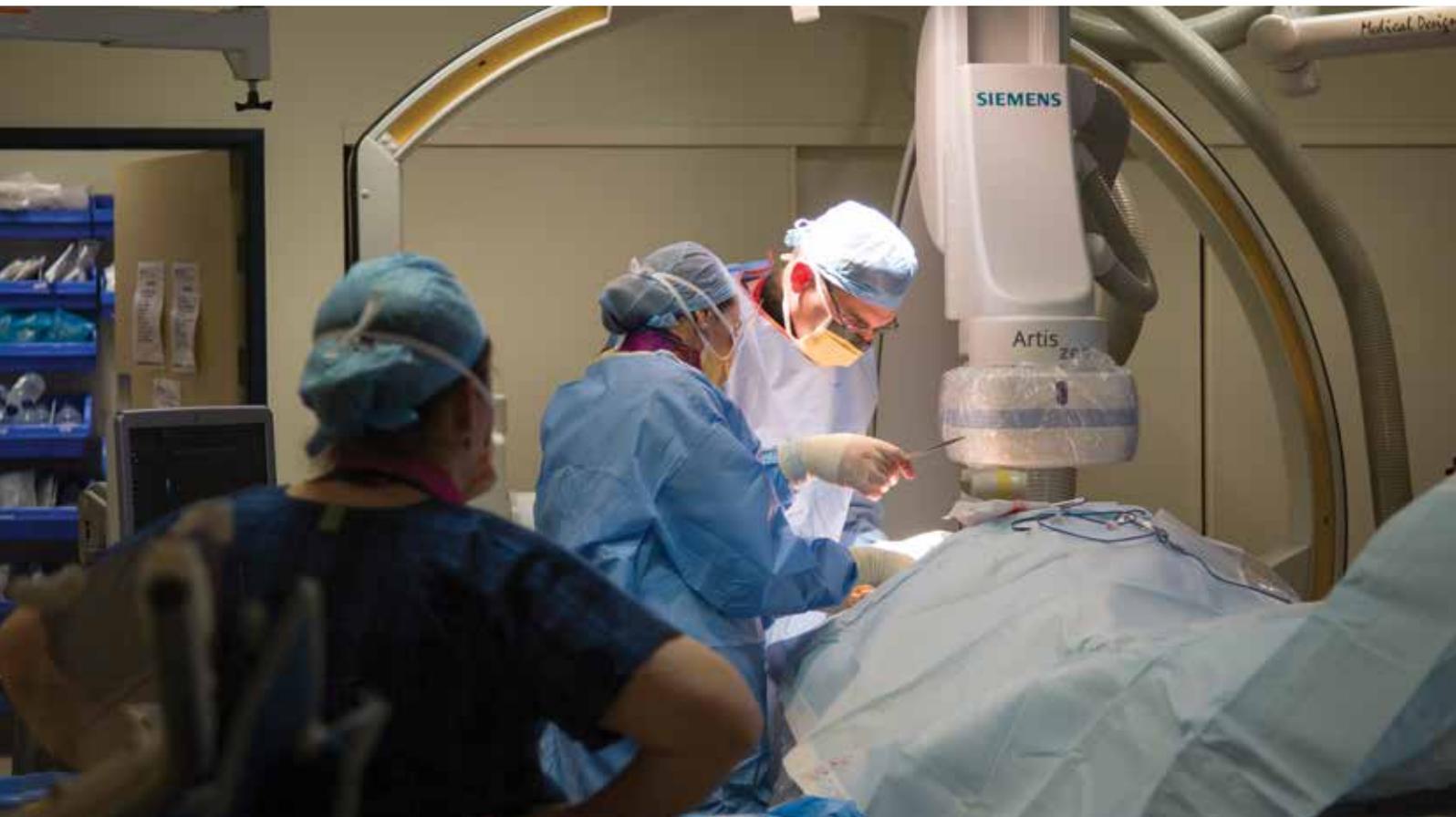
Dr Toby Cohen of Queensland Vascular is an endovascular surgeon with particular interests in minimally invasive vascular surgery, varicose vein surgery, aortic aneurysm disease and peripheral arterial disease. Dr Cohen comments that, *"The hybrid theatre is a combination of an old school sterile operating theatre with a radiology suite. Most of the larger public hospitals on the east coast of Australia are now using a hybrid theatre, however the new hybrid theatre under construction at St Andrew's War Memorial Hospital will be one of the first in a private hospital in Queensland."*

With the average age of the patient seeing vascular surgeons increasing, minimally invasive vascular surgery has become more important. The majority of these patients live comfortably at home and manage well with the rigors of daily life. However, a major surgical procedure can see them lose their independence due to a prolonged recovery. Percutaneous aortic aneurysm repairs, peripheral angioplasty and stenting have made a huge difference in the recovery times of these patients. The hybrid operating suite is an important element to faster recovery as it allows the combined open and endovascular treatment of difficult pathologies to occur at the same time.

"During the same period we saw a similar increase in lower limb angioplasties



DR TOBY COHEN



DR ANDREW CARTMILL PERFORMING AN ANGIOPLASTY

and stenting. Patients in the past that were not fit enough for open surgery are now being managed by percutaneous angioplasty and stenting under local anaesthetic. We find we are doing more interventions with the small vessels of the leg, saving more legs but having a higher amputation rate of the small toes.”

Improving the arterial inflow to the foot provides an opportunity for chronic ulcers or necrotic toes to heal without a significant physiological impact. The hybrid theatre allows surgeons to undertake both

“One of the clinical differences of endovascular surgery we have seen over the last three years in public hospitals is a 300% decrease in the rate of major amputations.”

of these procedures at the same time providing a very efficient service.

“You don’t lose what I like to call life fitness – doing things like getting up, going to the bathroom and doing your shopping. If you put an 85 year old in bed for week, they waste quickly and will find it very difficult to recover those life fitness skills.”

Similarly with the management of aortic aneurysm disease the vast majority of patients can be managed percutaneously with endovascular stents. This has seen a significant decrease in post-operative morbidity and mortality of elective cases. However the largest mortality advantage for endovascular surgery is in the management of ruptured aortic aneurysm which, in over half the cases, can be performed percutaneously under local anaesthetic.

For surgeons and other theatre staff, the hybrid theatre is a much safer working environment as well. If a vascular surgeon is working in a traditional theatre

and needs some type of imaging, the use of the image intensifier (II) machine exposes theatre staff to prolonged radiation, and over the duration of a professional career, can pose significant risk. In the hybrid theatre, radiation exposure is greatly reduced.

“Having good imaging in an environment where anything can happen, is very important. Occasionally you need to convert to an open surgical procedure after starting an endovascular case but the hybrid theatre will allow a safe transition if this problem occurs.”

The hybrid theatre is currently under construction at St Andrew’s War Memorial Hospital with completion scheduled for April 2014. ■

Queensland Vascular
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A country practice

1: Tell us a little bit about your background

I grew up in suburban Brisbane but I was born in Emerald in Central Queensland and spent my early years there and in Inglewood on the southern Darling Downs. I always had an affection for the bush and I liked the idea of being a country doctor. I trained in Brisbane at the University of Queensland and I received a Queensland Health Rural Scholarship which I signed up for in first or second year of med school. I always knew I wanted to work in the bush and in that sense I had no problem with the return of service requirement with the scholarship. One of the requirements of the scholarship is that you do two weeks a year in rural towns to get that experience and I went back to Inglewood and spent time with Dr Colin Owen and I really enjoyed that.



DR JOHN HALL

2: Tell us about the professional journey that lead you to working in Oakey

After a couple of years in Rockhampton, first as an intern and then as a JHO I spent some time in Mackay where I completed an advanced diploma in obstetrics to prepare myself for rural practice. I joined both the RACGP and ACRRM programs and moved out to Stanthorpe and that was my first experience in a busy rural hospital as an SMO. I completed both of my fellowships while I was in Stanthorpe and spent roughly four years there mixing obstetrics, emergency, inpatient, and GP work before settling in Oakey in 2009.

3: Why Oakey?

Well, my wife and I have four kids (all of whom were born while I was in med school, but that's another story) and following the stint in Stanthorpe they were at an age where we felt they needed more options with schooling and other activities. The opportunity came up at Oakey and with a major centre like Toowoomba just up the road it felt like a perfect fit. Oakey is a lovely little town, it's got an interesting mix in the community with croppers, graziers, an army base, some factories and a fairly large Indigenous population and with mining on the rise, it's an interesting place to be.

4. Tell us about the work that you are doing?

I have a dual role in that I am the Medical Superintendent of the hospital, responsible for the governance of the acute section and the emergency department as well as the governance of the 70-bed nursing home which we service privately through the general practice. The practice is separate to the hospital, it's a privately owned business in line with the Queensland Health Medical Office Right to Private Practice model which basically means that I'm employed by Queensland Health to maintain the hospital and do the on-call and after hours work there and respond to emergencies,

and during the day I'm released to run my private practice.

5. Do you keep in touch with your colleagues and latest practices in the city?

At any one time we also have three medical students with us that we supervise as part of our ongoing relationship with the University of Queensland and Griffith University and we're also heavily involved in their "Long Look" program which sees medical students staying for extended periods of time in the practice, sometimes up to six months. They shadow us here in the clinic as well as doing ward rounds and we have a purpose built room set up here for student training where they get to see patients on their own and also present patients to supervisors. We supervise resident doctors in the practice and GP registrars also.

We try and strike a balance between keeping strong relationships with the teaching universities, keeping hospital skills up to date and also we get to practice medicine in a close knit community where we follow patients through their life journey.

6. What advice would you give to your city cousins about life in the country?

I would recommend rural practice to anybody. Anybody who loves medicine, who loves seeing the undifferentiated patient, who loves a good mix of procedural, hospital based medicine and primary care would find it rewarding to work in the country. The range of cases, and the building of personal relationships with our patients from the cradle to the grave, it's very rewarding. ■

Dr John Hall
MBBS FRACGP
General Practitioner
Cherry Street Medical Centre, Oakey
T 07 4691 1750



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New technology gives hope and freedom

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According to the Colorectal Surgical Society of Australia and New Zealand approximately 5% of the Australian population suffer from faecal incontinence, with rates increasing sharply once they reach sixty-five years of age. Continence (or urgency) problems can have a profound impact upon patients with many sufferers experiencing several episodes of leakage a day, where they have to change their clothes, become house bound and unable to confidently engage in social or work related activities. New options are available in the management of continence and Dr Damien Petersen,



DR DAMIEN PETERSEN
COLORECTAL SURGEON

colorectal surgeon at St Andrew's War Memorial Hospital, believes it is a condition that patients need not suffer.

The most common cause of continence problems is injury to muscles or nerves of the anal sphincter through childbirth or rectal prolapse. If dietary intervention proves inadequate, Dr Petersen suggests the use of Sacral Nerve Stimulation (SNS). The muscles of the pelvic floor, urethral sphincters, bladder and anal sphincter muscles are all controlled by the brain through nerves that run from the sacral area.

The SNS device is in essence a modified cardiac pacemaker, similar conceptually to devices that have been in use since the 1970's. Instead of a battery in your chest connected by a wire to your heart, this is a battery connected by a wire to one of the nerves in the pelvis.

"It's not the case of incontinence equals SNS, but rather you work out what the most dominant issue is, and then direct the patient to the most appropriate treatment. Sometimes they may need more than one procedure to overcome a lifetime of problems. But there are a lot of cases where this relatively simple procedure can be life changing."

Results for patients who have had surgery to repair either prolapse or sphincter defects can drop over time and it's this cohort where SNS can provide an excellent solution.

"Surgical intervention for either the prolapse or sphincter repair are both fairly invasive procedures and quite painful for a number of weeks following surgery. The advantage of SNS is that it's a low risk, minimalist procedure."

Implantation of the wire into the nerve and installation of the device is combined in a thirty-minute procedure. The battery in the device lasts approximately seven years, however development of a smaller rechargeable battery is in the pipeline and will be available soon.

"Before the patient leaves the theatre the device is turned on and it works immediately. Someone having two to three accidents each day can notice a huge improvement almost immediately."

"...we're not actually sure how the device works!"

It is not known whether SNS works by changing motor output or by enhancing contraction. We don't know whether it works by increasing the sensory capacity or by sending signals back up to the brain and then back via the sympathetic nervous system to stimulate other aspects, we simply don't understand."

"You can have patients who are having multiple episodes of incontinence per day and whose lives are ruled by their capacity to get out and you can significantly reduce these episodes of incontinence. It can be incredibly rewarding work, transforming a life with this simple procedure."

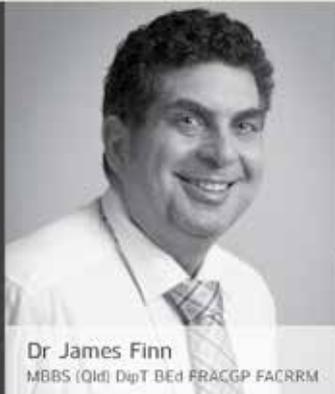
Dr Damien Petersen of Spring Hill Specialist Group is a colorectal surgeon based at St Andrew's War Memorial Hospital. ■

Spring Hill Specialist Group
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F 07 3831 0622

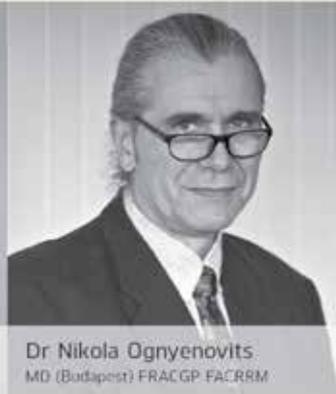


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Dr James Finn
MBBS (Qld) DipT BEd FRACGP FACRRM



Dr Nikola Ognjenovits
MD (Budapest) FRACGP FACRRM

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Dr Michael Adsett
Cardiologist

The Quiet Achievers

Cardiac care in a brave new world

Some of the exciting work underway with the Queensland Cardiovascular Group (QCG) involves the application of new technologies. All GPs will be familiar with pacemaker procedures and the implantation of other implantable cardiac devices as they have been in use for over fifty years. The transformation in size, shape, functionality and battery life over the last ten years however is nothing short of phenomenal. In the recent past, the most common hesitation patients have had with the use of pacemakers and implantable defibrillators has been the fear of lead or device malfunction resulting in inappropriate shock delivery or a failure of pacing.

Dr Michael Adsett is a cardiologist and partner with Queensland Cardiovascular Group, based at St Andrew's War Memorial Hospital. Dr Adsett completed his fellowship at the St Andrew's Heart Institute, training in cardiac electrophysiology procedures under the supervision of Dr Wayne Stafford and Dr John Hayes. Dr Adsett noted that *"Whilst lead problems will never be eliminated completely, the leads that we are implanting now have a robust track record. There are continuing refinements being made in terms of lead and device manufacture. Device algorithms that differentiate rapid rhythms from noise/harmless rhythms continue to be refined. This should lead to further reduction in inappropriate shocks."*

As with most consumer technologies, pacemakers and ICD's are getting smaller with longer battery life and that trend is set to continue into the future. And leadless pacing technology will mean that miniaturized devices will be



implanted at the tip of the heart with no leads at all attached which substantially reduces the overall vulnerability of the device. This combination of leadless miniaturisation may also allow the capacity to pace two or even more sites within the heart to address issues such as resynchronization therapy. One of the most exciting innovations however with these electrocardio technologies, for both patients and health professionals, is in the area of remote monitoring.

"Wireless capability and communication that can notify us of changes in heart rhythm, particularly detection of atrial fibrillation (AF) is already in use. AF which is linked with stroke can be identified sooner and allow the introduction of an appropriate anti-clotting drug to keep the patient protected. It might otherwise go unnoticed for up to a year until the annual pacemaker check."

All current generation defibrillators, and soon the manufacturers of all pacing systems, will have wireless transmission capacity. The patients are provided with a little base station unit, a bit like the base station unit for a cordless phone. The pacemaker and that unit are then

able to communicate with one another. At the moment the traffic is all in the direction of device data sent to the unit and then to a server but soon we will also have reverse programmability.

"We will be able to undertake not only the follow up, but we'll be able to adjust programming of devices without people having to leave their home. This is an obvious bonus for our patients who live out of town and it may well become the norm that many of our patients might be implanted with a device and then be followed up without need for clinical visits. They can be monitored remotely in the longer term. Very exciting stuff!"

QCG is one of Australia's leading providers of cardiovascular medical services. Based at St Andrew's, QCG has a proud legacy of leading the way through the introduction and implementation of new technologies and procedures. ■

Queensland Cardiovascular Group
T 07 3016 1111
F 07 3016 1199
www.qcg.com.au

Agilitas launched at St Andrew's



St Andrew's VMP and Parkinson's disease specialist Dr Rodney Marsh teamed up with local technology company Bright Devices recently to launch a world-first product that alleviates one of the major symptoms of Parkinson's disease.

After five years of R&D, the product – Agilitas – was officially launched at St Andrew's War Memorial Hospital on World Parkinson's Day, Thursday 11 April. Agilitas was designed and developed to overcome a debilitating Parkinson's disease symptom known as "freezing of gait", which affects around 28,000 Australians.

People who suffer freezing of gait "get stuck" and can't walk forward, especially when they are in confined spaces such as doorways, near obstacles, while turning or starting to walk. Freezing of gait prevents people from walking freely, increases the risk of falls and can lead to social isolation.

Agilitas shoots a laser beam onto the ground in front of the wearer. Observation of the laser sends a signal to the brain and prevents the person from freezing.

For more information about Agilitas, freecall 1800 91 31 41.

Agilitas

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The simplest questions are often the most important!

Reflections from a hernia nerd

Dr Phil Lockie is an Australian and UK trained upper GI and laparoscopic surgeon and is a self-proclaimed hernia nerd. Following his training in the UK, he completed an Upper GI Fellowship at Royal North Shore Hospital in Sydney and this was followed by a Laparoscopic Surgical Fellowship in Canberra. During his training, he also completed a research thesis resulting in a Master of Philosophy Degree and consequently won the UK Intensive Care Society's Travelling Fellowship. Dr Lockie was awarded his Fellowship from the Irish College of Surgeons in 1985 and in February 2003 won the Gold Medal at the Intercollegiate Examination in General Surgery and was awarded his Fellowship from the Australian College of Surgeons in 2006.

As a member of the European Hernia Society, Dr Lockie keeps up with the

latest information regarding hernia repair, and applies it to his practice as appropriate. As a laparoscopic surgeon, Dr Lockie prefers laparoscopic hernia repair wherever possible. As a specialist trained in both upper and lower abdominal surgical procedures, Dr Lockie has extensive experience in the laparoscopic repair of epigastric, umbilical, incisional, inguinal and femoral hernias. However, the most common question he is asked by general practitioners has less to do with the specific technique for procedures but rather is more related to the timing of surgical intervention.

Do you have to repair an asymptomatic hernia?

"The answer is no you don't have to. The current guidelines are that you fix the hernia if and when it starts to interfere with the patient's lifestyle. So where previously

if the patient came in for a relatively asymptomatic hernia and the doctor says you've got to get it fixed, I might say it doesn't have to be fixed right now or next week. The chances are if you are relatively young at some point in your life you're going to want to get it fixed."

"If you're seventy five or eighty and you have a hernia and its not causing you any problems, then you don't have to have it fixed, but equally if you're seventy-five and you say 'look by the ninth hole playing golf its starting to bother me', well then that's a reason to fix it."

"If you've got a hernia and its not causing you any problems, then we'd probably say let's make a time that works for you. Particularly if you're a busy professional with a lot of obligations and they ask if it can wait till their busy period is over, I'd say sure no problem."



DR PHIL LOCKIE PERFORMING A LAPAROSCOPIC HERNIA REPAIR



“Obviously there is very small risk of hernia related complications such as strangulation or obstruction however this occurs very rarely and can be attended to by me at the St Andrew’s Emergency Centre.”

Dr Lockie has provided out of hours emergency general surgical cover for St Andrew’s EC for the last 6 years. He provides out of hours surgery for general surgical conditions such as acute appendicitis, acute abdominal conditions such as diverticulitis, bowel perforation and abscesses. As an upper GI surgeon, Dr Lockie regularly performs laparoscopic cholecystectomy, for elective and acute or “hot” gallbladders.

Dr Phil Lockie consults at St Andrew’s Hospital Specialist Centre and has his main rooms at The North West Medical Centre in Everton Park. Dr Lockie has also invested in “Go-To-Meeting” system for internet telecasting for rural and remote patients. This system allows patients to have “face to face” internet consults from their own home. Dr Lockie has been able to offer consults to patients from places ranging from Longreach to Burketown.

Throughout his practice Dr Lockie applies a team-based approach to patient assessment and treatment. For hernia patients this may involve an exercise physiologist to aid post operative recovery, and in his bariatric practice he offers pre and post surgery psychology, dietician and support group. Together with his wife Shirley, whose background includes a Master’s degree in clinical science, a Registered Nurse and Perioperative Advanced Clinical Practitioner, they provide all patients with 24 hour mobile, txt and e-mail support. ■



DR PHIL LOCKIE,
UPPER GI,
BARIATRIC,
LAPAROSCOPIC
HERNIA SPECIALIST



Queensland Diagnostic Imaging

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Further information will be released as we go forward, please direct any queries to Dan McCulloch. We look forward to continuing to work with St Andrew’s in providing a high quality imaging service.



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Talk to me!

Reflections on a system that has trouble connecting the dots...

Dr Robert Brown is busy GP based on the north side of Brisbane. Dr Brown served as a doctor in the Australian Army, he was a past president of the AMA Queensland and has a special interest in diabetes care. He also runs a thriving medical centre with 12 GPs, 5 nurses and an allied health team delivering services including child, adolescent, adult and family care, diabetes care, skin cancer, wound care, antenatal and post-natal care.

In any thriving business environment, communication between customers, primary, secondary and tertiary service providers, is the key ingredient to sustained quality outcomes for stakeholders. When the customer is the patient and the epicentre of this system, the stakes are high, and Dr Brown thinks that the system needs a shakeup when it comes to information communication.

"I don't think that any of us are guiltless in this, the problems are shared and interwoven. I'll be trying to talk from the point of view from GP to specialist and vice versa, and also to a hospital but the person who misses out is the patient."

The key players in this word game are the GP, the specialist (and their staff) and the hospital staff. Whether it's via email, online forms, fax or telephone, the cracks in the system seem to show as soon as information starts to travel.

"The patient will come in and see you and they assume, as I've had already today, that you've got information. And not only assume, they've been told that you have the information, as this one was, by the local hospital. The patient has said to staff at the hospital 'I'm going to see my doctor

next week' and they respond 'That'll be fine, he'll have all of the information.' Well I've got none, I didn't even know that the patient was in hospital!"

Facsimile transmission is an aging workhorse of the telecommunications landscape and despite the rise of desktop 'faxware', the medium is viewed by most IT service providers as unsafe, prehistoric technology. Without faxes however, the entire medical communication system would grind to a halt within a day. And while many clinics can send desktop faxes electronically, public hospitals aren't set up to receive them, instead requiring dedicated POTS line machines.

"This puts a lie to the whole eHealth thing!!!"

Within the hospital sector, different departments within a single hospital might have different systems where one might use fax and the next section using secure electronic message. In some cases different departments within a single hospital might be using different patient management systems where Cardio-thoracic might be using a commercial product (such as 'Genie' or 'Medical Director') and Neurology might be using an in-house program so they can't even talk to each other.

"If the patient goes ahead and has surgery, we often don't get a notification of when they are having it done. They usually let us know that there's been an admission, but not always. And if we get a discharge summary, the only ones we get early will be from the pharmacy usually, and sometimes

we might get a nursing summary from the ward. But the medical summary may not arrive for weeks and by that stage I've already seen the patient. We might have a diagnosis at this point, but usually not! Often I'll have to read the pharmacy summary and draw conclusions from that, ...quite often we don't have a clue!"

Whether it's the backlog of communication from the surgeon's staff, the patient notes being in the wrong format, the fax not talking to the computer or the departments not talking to each other, the GP can end up with egg on their face and the patient is the meat in the sandwich.

"If all of our communication was electronic, if means of messaging were more consistent, and if we're ever going to get eHealth working, we've got to start pulling this together now." ■



DR ROBERT BROWN
TAIGUM CENTRAL
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TAIGUM
T 07 3265 4555

ACL Fact Sheet with Dr Dale Rimmington

Dr Dale Rimmington is a specialist orthopaedic surgeon who has special interest in knee and shoulder surgery. Dr Rimmington has consulting rooms and is an accredited VMP at St Andrew's War Memorial Hospital in Spring Hill. Dr Rimmington is an Associate Member of the Australian Orthopaedic Association and a member of the American Orthopaedic Society for Sports Medicine.

What is the Anterior Cruciate Ligament?

The ACL arises from the posteromedial corner of medial aspect of lateral femoral condyle in the intercondylar notch. Its fibres travel forward to where it attaches to the tibia in a fossa in front and lateral to anterior spine over a broad area as far forward as the transverse meniscal ligament. It is made up of multiple collagen fascicles. It is a key structure in the knee in resisting anterior tibial translational and rotational loads. Its mean length is 32mm and width of 7-12mm.



ARTHROSCOPIC IMAGE OF INTACT ANTERIOR CRUCIATE LIGAMENT

How does the ACL rupture?

ACL ruptures most commonly occur in sports that require sudden changes of direction and decelerations, such as football (all codes), netball, basketball and skiing. Approximately 70% occur in a non-contact situation and many patients report a pop or click and are unable to continue to play.

Who ruptures the ACL?

There are approximately 100 000 ruptures of the ACL per year in the USA. They occur in a younger sporting population (15-40 y.o.). Female athletes are 2-8 times more likely than male athletes to rupture the ACL.

Does everybody with an ACL rupture need surgery?

Not everybody who ruptures an ACL requires surgery. If patients experience instability or other mechanical symptoms surgery is usually indicated. Most patients can cope without a functioning ACL for activities or daily living. If patients wish to return to sports usually reconstruction is indicated.

What are the options for graft?

There are multiple graft options; autograft (hamstring tendons, middle third patella

tendon, quadriceps tendon), allograft and synthetic options. Repair is occasionally an option if the ACL avulses with a piece of bone (usually paediatric injury).

What does the surgery involve?

Surgical repair of the ACL is unsuccessful unless the rupture occurs as an avulsion fracture (paediatric). Therefore reconstruction is performed which involves drilling tunnels in the proximal tibia and distal femur and passing the graft through the tunnels and securing the graft in the tunnels to recreate a new ligament. Other intra-articular pathology can be addressed at the time such as meniscal tears and cartilage lesions. ■



DR DALE RIMMINGTON,
ORTHOPAEDIC SURGEON

Q&A WITH TONY JONES

SATURDAY 20 JULY 2013
HILTON HOTEL BRISBANE

BOOK NOW AS SEATS ARE LIMITED

To register for this event or for more information please call Susan Walsh on (07) 3834 4371 or email on susan.walsh@uhealth.com.au or download from www.uhealth.com.au/sawmh/gpeducation



GP Medical Series
QUEENSLAND
Q&A



Planned Healthcare Offers Opportunity For Innovative Medical Care

Queensland is the incubator of a new approach to planned healthcare that makes use of digital technologies, according to Dr Christian Rowan, Director of Medical Services at St Andrew's War Memorial Hospital and President of the Australian Medical Association Queensland.

The opportunity this provides the entire medical community is exciting, says Dr Rowan, who is also the Deputy Chief Medical Officer of UnitingCare Health.

Two new projects – one in South East Queensland's burgeoning western corridor and the other on the fast-expanding Fraser Coast – are both being planned to provide holistic patient care.

There is a unique opportunity to plan future delivery of health services across the healthcare spectrum, integrating health, wellness and disease prevention, primary care and acute care, said Dr Rowan.

Sharing information using digital technology and creating synergies between primary

and secondary care are at the heart of both Springfield Central's Health City and Hervey Bay initiatives, Dr Rowan said. Health City, which is being developed on a 52-hectare campus at Greater Springfield, west of Brisbane, will be Australia's first purpose-designed health precinct.

"The building of an innovative health city precinct is giving the community at Greater Springfield an opportunity to create an integrated model of primary and secondary care which also considers education, training and research," Dr Rowan said.

Two key components of Greater Springfield are Education City and Health City. Education City is already well advanced, Greater Springfield already is home to a university, a TAFE, nine schools and eight childcare centres, and now Health City is taking shape alongside it. A key attraction at Health City and for the entire Greater Springfield development is the availability of high-speed internet necessary for effective e-health.

A UnitingCare Health initiative which is already taking the lead in digital health planning is the new St Stephen's Hospital at Hervey Bay which will serve the entire Fraser Coast region and its population of more than 100,000. The \$87.5million hospital, opening in 2014, will be Australia's first fully integrated digital hospital.

The electronic strategy for the new hospital is to ensure medical staff use shared information and utilise wireless technologies to work more efficiently and safely. All medical records, X-ray and pathology results will be accessible by doctors and nurses anywhere in the hospital, using computers in patient rooms, electronic devices and laptop computers.

Dr Rowan said a key objective at Hervey Bay was to improve the patient and clinical experience.

"The mobility and improved access to clinical information anywhere and at any time will help improve core processes and workflows and enable the development of co-ordinated models of care."

He said both the Hervey Bay and Springfield projects were examples of where health planners, industry and clinicians could work together across the private and public health systems, to provide optimal healthcare throughout a person's life.

"We need to break down the barriers between primary and secondary care, and public and private systems, to ensure we keep our communities as healthy as possible, in the most cost-effective way. Better planning, and making use of technologies that were not dreamt of a few decades ago, gives us the opportunity to do things in Queensland that the rest of the country can learn from."

"...an integrated model of primary and secondary care which also considers education, training and research."



ARTIST'S IMPRESSION OF THE NEW ST STEPHEN'S HOSPITAL IN HERVEY BAY

Meet the new St Andrew's Business Unit

In June this year the St Andrew's marketing and business development groups merged to form the St Andrew's Business Unit (SABU).

The SABU Team:

Helen Whelan – Business Unit Manager
Susan Walsh – Project and Events Manager
Joanne Smith – Administrator

What we do:

We support Queensland GPs with the following initiatives:

1. CPD Program
 - Dinner Seminar Series
 - Weekend Conference Series
 - Specialty CPD Conferences – Sports Injury Conference, Movement Disorders Symposium, Pain & Addiction Forum
 - GP Medical Series Queensland
2. Metro GP Outreach Program
3. Rural / Remote GP Outreach Program
4. GP e-bulletin
5. Best Practice Journal
6. Quick Referral Guide

Our GP partners are:

- AMA Queensland
- Australian General Practice Network (AGPN) – Medicare Locals - Metro North Bne, Central & North West Qld, Central Qld, Darling Downs & Sunshine Coast
- CheckUP (GP Queensland)
- Rural Doctors Association Queensland (RDAQ)
- Royal Australian College of General Practitioners (RACGP)
- Australian College of Rural and Remote Medicine (ACRRM)
- Queensland Remote Medical Education (QRME)



(FROM LEFT) SUSAN WALSH, HELEN WHELAN AND JOANNE SMITH
ST ANDREW'S BUSINESS UNIT.



Letters to the Editor

If you have a view or opinion about something you've read in this edition of *Best Practice*, why not write a letter to the editor? Letters exist to provide a forum for public comment or debate and provide an opportunity for you the reader to express your opinion or point of view.

If you have an idea for a story that you would like to see included in the next edition of *Best Practice*, email your suggestion with a short description of why you think the topic will be relevant to Queensland GPs.

Please email submissions to:
susan.walsh@uhealth.com.au



Are you in control?

As a keen golfer it often amuses me just how many players, after a poor round of golf, will reflect on their game and focus on factors outside their control such as wind, course conditions and pin positions. These external factors do have an impact on the player's score and should be considered, however they cannot be used as an excuse for playing a bad round of golf.

When looking at money matters people often fall into the trap of focusing on external factors – those out of their control such as tax, investment returns and the state of the economy. People would be far better placed if they were to focus their attention on a financial game plan, one that includes proactive goal setting and regular progress reviews. The external factors will always have an impact and should be taken into account when establishing and reviewing the financial game plan. They should also be taken into account when formulating a road map to reach the desired goals but they should not become the scapegoat for failing to achieve long-term financial wellbeing.

Areas out of your control

It is usual for a pre-election Federal Budget to have a number of handouts and tax cuts but this year's budget deficit put paid to any major incentives. While there were no tax increases, there will be an increase in the Medicare Levy from 1.5% to 2% from 1 July 2014 to fund the National Disability Scheme. For a tax payer earning \$200,000 this will mean an extra \$1,000.

Net Medical Expense Tax Offset (NMETO)

After making significant reforms to the NMETO in the 2012 budget, the government has decided that it will be completely phased out from 1 July 2013. While the NMETO will continue until 2019 for out of medical expenses related to disability aids, attendant care or aged care expenses, it will only be available for the year commencing 1 July 2013 if a claim is made for this financial year finishing 30 June 2013.

Areas within your control

Superannuation

Most medical specialist clients maximise their contributions to super in order

to minimise personal tax. The budget changed some of the rules so it is worthwhile to recap these changes. Notable highlights include:

- The contribution cap is \$25,000 for everybody this financial year
- For next financial year if you are over 60 the cap is raised to \$35,000
- From 1 July 2014 this higher cap of \$35,000 will apply to anyone over 50
- If you employ a spouse or partner it is possible to contribute above the 9% requirement up to \$25,000
- It is possible to add extra to your super through after tax contributions of \$150,000 per year

Pre-paying interest on investment and business loans

With interest rates at historically low levels it is worthwhile looking at pre-paying next year's interest before 30 June 2013 in order to obtain the deduction this year. A number of medical practitioners will have borrowings for property and shares that could be fixed and prepaid for 12 months.

Pre-pay rent

If you are in private practice a common strategy to reduce your business income is to pre-pay rent for next financial year before 30 June 2013.

Staff superannuation

Super guarantee payments do not need to be made until the 28 July 2013 for any employees. These payments can be made this financial year to bring forward the deduction. ■

Brian Pert

Brian Pert is a certified Financial Planner and Director and adviser of Pert & Associates.

To download a copy of their latest White Paper on "Creating Financial Independence for Medical Specialists", visit www.pertassoc.com.au

"...focus on a financial game plan, one that includes proactive goal setting and regular progress reviews."





DR MICHAEL ADSETT, PROF JOHN FRASER AND DR BRUCE GARLICK CELEBRATE AT DR RIVERS' FUNCTION



DR JOHN RIVERS AND DR MICHAEL GARDNER AT DR RIVERS' SAMI CELEBRATORY FUNCTION



DR TOM MOORE (BROWNS PLAINS) WINNER OF THE BEST DRESSED COMPETITION AT THE COLOURS OF THE RAINBOW CPD WEEKEND WITH A RAINBOW FUNKSTER



FROM LEFT: LESLEY HOLDEN, GEOFFREY ROBERTSON QC, DR CHRISTIAN ROWAN, JANE ROWAN AND HELEN WHELAN AT THE HYPOTHETICAL



GEOFFREY ROBERTSON QC WITH PANELLISTS FROM THE HYPOTHETICAL



MATT EASTBURN (MEDTRONIC), PROF HELEN CHENERY (APCN) AND JAMIE STANISTREET (MEDTRONIC) ENJOY THE HYPOTHETICAL



DR MARK BALDWIN AND DR ALEX MARKWELL



HYPOTHETICAL PANELLISTS PROF PETER SILBURN, DR CHRISTIAN ROWAN, DR JOHN HAYES AND PROF JOHN FRASER

CALENDAR OF EVENTS 2013

CPD WEEKENDS			
14 –15 September	How to Treat...	InterContinental, Sanctuary Cove	12noon Sat – 12noon Sun
CPD EVENINGS			
Wednesday 18 September	Latest Developments in Primary Care	Victoria Park Function Centre, Herston	6:30pm – 9pm
Wednesday 13 November	Silent Epidemics	Clovely Estate Cellar Door, Red Hill	6:30pm – 9pm

SAVE THE DATE:

St Andrew's Gala Dinner

Saturday 2 November 2013 – Hilton Hotel, Brisbane

Fine wine and food will be accompanied by live music, entertainment and fantastic prize give aways.



Emergency Centre	07 3834 4455
GP Hotline	07 3834 4490
Rehabilitation	
Inpatient Services	07 3834 4391
Day Patient Services	07 3834 4285
StAMPS	
St Andrew's Multidisciplinary Pain Service	07 3834 4525
Coeliac Centre	07 3367 1065
Pelvic Medicine Centre	07 3834 4399
Day Infusion Centre	07 3834 4493
Sleep Centre	07 3834 4959
Business Unit	07 3834 4210



Quality
in Health
ISO 9001+
Core Stds



St Andrew's War Memorial Hospital's quality management system has received ISO 9001 certification ensuring the hospital's safety and quality system meets the highest international and national standards. St Andrew's earned ISO 9001:2008 and Core Standards for Safety and Quality in Health Care certification in October 2012 after a very successful audit.

St Andrew's War Memorial Hospital's certification is aligned with international best practise and complies with the 10 standards set by the Australian Commission on Safety and Quality in Health Care.